DOCUMENT RESUME

ED 044 708 CG 004 831

AUTHOR Cummings, Nicholas A.
TITLE Exclusion Therapy: An Alternative to Going After The Drug Cult Adolescent.
PUB DATE 4 Sep 69
NOTE 7p.; Paper presented at the American Psychological Association Convention, Washington, D.C., August 31-September 4, 1969 and in Miami Beach, Florida, September 3-8, 1970

EDRS PRICE EDRS Price MF-$0.25 HC-$0.45
DESCRIPTORS *Adolescents, Drug Abuse, *Drug Addiction, Lysergic Acid Diethylamide, Psychotherapy, *Socially Deviant Behavior, *Therapy
IDENTIFIERS Exclusion Therapy

ABSTRACT

The author views middle class adolescent, drug cult drop-outs as lacking, for a variety of reasons, father figures with whom they could interact in a normal and healthy rebellion. On this basis, he devised exclusion therapy which establishes, for resistive clients, a kind of severity of initiation. The paper describes the process as follows: a strong, admirable therapist who seems to hold out the opportunity to help the youths grow up, demands of them seven full days free of addiction prior to being admitted to therapy. Individual therapy and subsequent group therapy are both kept continuously contingent on "cleanness." The paper describes the population with which exclusion therapy was developed: 282 adolescents, age 15-25, who self-described themselves as hippies, drop-outs, drug freaks, etc. The major emphasis of the technique is elaborated, with a constant focus on the consistency of the father-figure therapist. The discussion which concludes the paper stresses that exclusion therapy is not for everyone, but that it had been effective on a large percentage of its resistive client population. (TL)

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EXCLUSION THERAPY: AN ALTERNATIVE TO GOING AFTER THE DRUG CULT ADOLESCENT

Nicholas A. Cummings, Ph.D.*

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Summary of Presentation to the Division 29 Symposium: New Treatment Approaches to the "Untreatable" Teenager. Annual Convention of the American Psychological Association, Washington, D.C., September 4,1969. Repeat presentation at the Annual Convention of the American Psychological Association, Miami, September 7, 1970.

The Growing "New Breed"

The classical conflict situation of the struggle with a strong, overly strict father is strikingly absent in the lives of middle class asolescent drop-outs. More traditional therapies, designed to correct the neuroses arising from the classical conflict situation, have limited application in those patients who have not had the opportunity to fullfill their own identity through the necessary degree of father-child struggle.

On the otherhand, it is equally a mistake to resort to a pseudo-guru type situation wherein the adult "cops-out" to his own unresolved authority problems, becomes a super-adolescent, and either gleefully or subtly encourages the teenager to act-out against the society-parent. This again deprives the adolescent of the necessary confrontation with the father-image which will become the basis of his identity. It is too often an unfortunate fact that adults, viewing the adolescent drug subculture, tend to react in one of two ways: (1) angry, outraged repressiveness, or (2) naive romanticizing. Years of experience in the Haight-Ashbury district of San Francisco have demonstrated there is nothing romantic in the pain of drug dependence, be it for pot, speed, acid or smack (marijuana, amphetamines, LSD, heroine).

The lack of a father figure with whom the child can interact in a healthy rebellion often results from the absence of a father (death, divorce, chronic illness, commuting), more often from the presence of a "squishy" father (weak, passive, "castrated"), but most often from the presence of an overly domineering or overly accepting mother who interferes in the normal father-child struggle and promotes a mother-identification in the son. Consequently, sex differences become vague, the ability to derive personal satisfaction from achievement and from overcoming obstacles diminishes or disappears, and the adolescent strives for greater and greater total "passive" acceptance "just as

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*The author is the Chief Psychologist of the Kaiser Foundation and the Permanente Medical Group (San Francisco), the Co-Director of the Golden Gate Mental Health Center, the Founding President of the California School of Professional Psychology, and the Immediate Past President of the California School of Professional Psychology, and the Immediate Past President of the California State Psychological Association.

I am," and without having to perform up to a standard that a father would require. In her zealousness to be opposite from her perception of her "castrating" mother, the girl will often overly mother a weak, passive or "squishy" man, even to the extent of working to pay his drug bill while he sits about meditating or writing poetry.

The Therapy

"Exclusion therapy" devises a series of techniques by which patients are required to earn their way into the treatment milieu and continue to keep their places there by performance. Failure to meet agreed upon standards and rules results in degrees of exclusion from treatment. The adolescent is usually remanded to treatment by his parents or the juvenile authorities, and he comes prepared to reject the therapist or, at best, play the game in order to "get along." The insistence that he can not enter the treatment situation until he fulfills certain conditions catches him by surprise, sets up a challenge, and more often than not provides an otherwise absent motivation to enter treatment.

If the therapist is seen as a strong, admirable person who seems to hold out the opportunity to help the patient grow up and become a self-respecting person, he can often be "hooked" into treatment. Then, rather than drive patients away, these techniques have been found in San Francisco's drug cult to produce a commitment to the treatment situation. This gives the patient the opportunity to enter into a temporary identification with the therapist who is (1) self-respecting, (2) stronger than his mother, and (3) more honest and concerned than his father. A father-child struggle ensues which results eventually in the patient's greater differentiation of his own identity and a pride in his own achievement.

The Population

Exclusion therapy was developed over a four year period by the author and his colleagues with 282 adolescents ranging in age from 15 to 25. The therapeutic contract with the younger age group was facilitated by California law which permits a practitioner to see anyone over age 15 without parental consent. The inclusion of patients up to age 25 is not surprising when one realizes all were drifting in one of the subclutures in the Haight-Ashbury or Telegraph Avenue (Berkeley) districts in much the same way as the younger residents of those areas. At times they tended to rationalize their adolescent orientation by pulling age rank on the younger group members, but they were quickly put down by the latter who referred to them as either "super-annuated teenagers" or "infra-grownups." By patient consensus the period between 25 to 30 was known as the middle years separating adolescence from old age.

The patients did not hesitate to attach such subculture labels to themselves as hippies, street people, drop-outs, drug freaks or flower children. They despised the designation "kids." Once off dope there was agreement they were all disturbed emotionally, but they made an unprecise differentiation between the younger and older "adolescents" in degree of severity, and generally agreed that if you are still freaking-out over age 25 there was probably a mental disturbance of incurable (i.e., adult) proportion.

All had money when they wanted it. The offspring of poor families do not subject themselves to the almost intolerable living conditions known as the

"hippie pad". Four years ago when the author questioned his first dishevelled, unbathed drug cult adolescent as to his ability to meet a private fee, he was startled at the answer: "No sweat, doc. When mums hears I want to get my head shrunk she'll be so gassed the bread (money) will be in the first envelope." The patient was informed he would be permitted six sessions on "mums." The seventh and all subsequent sessions would be on him, a rule which has sucessfully and therapeutically been enforced ever since with all patients in spite of universal initial protests. In addition, the patient must pay for his sessions honestly; selling dope, panhandling or hustling one's body, all frequent recourses, are viewed in the same light as "mum's bread," and are not allowed.

The Technique

The adolescents came to us usually for one or both of two reasons. The first was in response to authoritarian pressure, and included those young persons who had learned from their peers on the "street" that the act of presenting oneself to a "shrink" was sufficient to forestall the draft board, angry parents who were threatening to cut-off the monthly remittance check, or the wrath of juvenile authorities, the police and the courts. These patients merely wanted to play the game, and the therapist's refusal to see them unless certain fair and realistic conditions were met was particulary effective. The second group were those patients who were actually hurting. They were "strung-out" or were experiencing the lingering effects of a bad trip, but at best were seeking only temporary relief so that they could resume their way of life.

The ultimate therapeutic effect of Exclusion Therapy may result from the unrelenting firmness, fairness and consistency of the therapist, but the patient is unaware of these features during the first session. It is important, therefore, to "hook" the unmotivated adolescent into treatment in the first session, otherwise he is not likely to return for the second session, to say nothing of sufficient sessions necessary to demonstrate the therapist's consistency. The therapist has only the first half of the initial meeting to gain enough information to use as leverage in making the therapeutic contract during the second half of the interview. In the beginning he must simply ignore the adolescent's defensive attitude of sneering superiority and his lies. The fact is, that in spite of the complaint that adult society is hypocritical and dishonest, drug cult adolescents lie a great deal, though they may rationalize their falsehoods as a "putting on" or a "putting down" of society. In hooking the adolescent into treatment, the therapist must find (1) something genuinely postive about the patient and (2) a real hurt or concern that is plaguing him. He then ignores the manifest reasons that brought the patient in, and demonstrates an acceptance and understanding of the patient by a dramatically accurate discernment of the adolescent's hidden pride and fears. By quickly and skillfully penetrating the patient's determination to remain aloof, the therapist demonstrates a craftsmanship which will be regarded as hope and the ability to really help the patient. It also taps his innermost craving for a male hero who will counteract his disdain for men (including himself) resulting from having equated all maleness with his "cop-out" father.

Regardless of protests to the contrary, most drug cult adolescents are secretly proud of their "square" accomplishments made prior to dropping out. They are afraid to reveal their homesickness, over-sensitivity and vulnerability, and they cover it with a startling form of inflammatory cynicism to which the therapist must not fall prey. For example, terror that LSD may have damaged her chromosomes may lead a yound woman to declare, "Even if I have defective children, LSD makes me feel so groovey that it's worth it." Young men are deeply concerned over a sexual impotence which may have its roots in

masculine insecurity, but is certainly compounded by the debilitating effects of drugs, especially amphetamines and hard narcotics. His bragging only thinly veils his dismay at his own need for greater sex orgies involving increasing numbers of people and an ever-widening circle of perversion as a necessary condition to sexual performance. He loudly affirms his ability to love because he fears intimacy is forever beyond his reach. The girl, in adopting the caretaker role with her "loser" boyfriend, longs for a strong, understanding man to take charge of her. She distracts herself from a gnawing fear she will never be an adequate wife and mother by helping her lover rationalize his fear that he will never be able to earn an adequate living. She has replaced the outer Puritanism of mother, church and society with an inner Puritanism which permits her to be sexually promiscuous but denies her an orgasm unless she has "stoned" this inner tyranny. These and the many other real features of the adolescent drug cult provide the basis by which the therapist must reach the patient within the first half of the initial session. He must be an uncompromising therapeutic agent, eschewing his temptation to play social philosopher in spite of society's apparent faults, for to do so would add legitimacy to the adolescent's own cop-out that it is not his inner turmoil, but society that is at fault. Timing, drama and enthusiasm are ingredients in the therapist to which the adolescent will respond. But there is no substitute for craftsmanship, for the therapist is required to rapidly formulate a direction which may appear to be nothing more than an inspired guess. To the extent the therapist is skilled, to that degree will his formulations be accurate and his execution of them be fruitful. The pay-off is an almost instant transference; the inaccurate approach is a total loss of the patient.

The therapist can tell immediately when the instantaneous rapport has been established, and he then proceeds to exclude the patient unless certain conditions are met. These are presented simply and straightforwardly. The drug user is required to "cold turkey" and remain off all drugs for the entire course of treatment. So clever have these patients become in compromising their inconsistent parents that the therapist must avoid being pulled into any argument as to what pills are allowed by forbidding all medications taken for the relief of tension, anxiety or their derivatives. But he also makes himself available day and night by telephone during the next three days, because the patient is going to need the reassurance that the therapist is there and interested, and as deeply committed to the patient's dignity as he requires the patient to be. One must be that committed when he goes so far as to even forbid aspirin! When he has been clean for seven consecutive days, he is granted an appointment. Adolescents usually call on the sixth day, at which point the therapist refuses to grant the appointment until the seventh day, to the very hour, has been fulfilled. Once the patient calls, he is given an appointment for that day, even if the therapist must see him late at night after a long and trying day. The lateness of the hour is no sacrifice to the adolescent, who usually is up most of the night, but he immediately recognizes the dedication of his therapist. The adolescent is further informed that each meeting he has to re-affirm his having remained "clean" or he is sent home. The fourth exclusion means expulsion, with no recourse for re-entry. Absences count as one of the three allowable exclusions. Within six sessions, if he has not already done so, the patient must arrange to pay for his own therapy. No "counterfeit" money, defined by the adolescents as income derived from dope pushing, prostitution and other illegal activities is acceptable.

Alcohol, food and therapy addictions are handled similarly with slight variation. The thin excuse that pot is no worse than alcohol has lost its meaning in the rediscovery of alcohol, in huge doses, by the drug cult. It is mixed with drugs, with speed and wine being current favorites. Food for the adolescent compulsive

over-eater can not be forbidden as can drugs and alcohol. Rather, the adolescent, usually a girl, is required to lose a certain number of pounds per week. She steps on the scale before the group at the beginning of every session, and is excluded even for one ounce less than the required weight loss. She is first asked how much she wishes to lose each week. Invariably she responds five pounds. She is told that even in losing weight she is a glutton, and she is told she will lose only two. Any pounds above the two required are "in the bank" and can be drawn upon during weeks when she has not lost weight. Most "fattys", as the group calls them in characteristic directness, build up large "bank deposits" with which they toy, always remaining within requirements. Therapy addicts, known as "couch freaks" and "mind fuckers" by their peers, are adolescents who have engaged in a mindless, endless searching with insight heaped upon insight with no satisfactory discovery of one's identity. Most have seen previous therapists, sometimes beginning in early childhood and involving their parents. They run to encounter groups, Zen meetings, growth centers, yoga instruction, natural food stores, astrology and mysticism. All have read or know of Edgar Cayce and other authors revered by the cult, and drugs have been employed ostensibly for "mind expansion." In order to be considered "clean" for purposes of remaining in the present treatment situation, these adolescents must refrain from all other forms of "therapy." They are even forbidden to complain to the supermarket checker if casually asked, "And how are you today?"

Many patients fit into more than one category of addict. In such cases, the adolescent is required to meet the treatment conditions ascribed to each of his "bags."

Once the adolescent has met the conditions for continuing treatment for several weeks, he is assigned to a group that is being formed at the time by his own therapist. All group members begin together, continue for six months and then disband. Some few may wish to continue (therapy addicts are excepted from this privilege) and will be assigned to a group forming at that time. All four types of addicts are fairly equally represented in each group, they are equally divided between men and women, and all members are required to attend all meetings. The therapist never alters the conditions of treatment as he originally indicated, but the group is permitted by majority vote to make additional requirements or rules of conduct. For example, a food addict that begins to drink heavily for the first time may be required by the group to refrain from drinking. A frequent new condition has to do with violence. Early in the course of treatment these adolescents who overwork the word "love" are shocked by their own violent feelings and by the number of group members who own knives, guns and other weapons. They soon require themselves to surrender all instruments of violence, and realize that LSD and other drugs are a form of self-violence.

Once the group sessions begin, individual sessions are discontinued on a regular basis. Each group member is permitted six individual sessions, and only six, which he may use at his discretion or never use at all. This limitation proved useful in discouraging a by-passing of the group in seeking understanding, while providing a realistic recourse to the therapist in time of need.

Each group is told that seven group members is the optimal number, so ten will be assigned because three will probably fail. This therapeutic "double-bind" proves quite useful, for no matter how difficult the course of treatment becomes, each adolescent is determined not to be one of the three who are likely to "bomb-out."

The Course of Treatment

Initially all of these adolescents seem unrelenting in their testing of the

firmness of the rules and the consistency of the therapist. Direct defiance is usual after two or three sessions, and it is in the early period of treatment that most of the allowable exclusions are used up. The drug users attempt to draw the therapist into a discussion of the alleged less harmful effect of marijuana as compared to alcohol, the difference between "habituation" and "addiction" and whether in actuality pot is addictive, a questioning of the research into LSD and chromosomal damage, and so forth. The therapist refuses steadfastly to be drawn into any other commitment than his contention that drugs for this particular adolescent have been harmful and that he will treat the individual only if he can relate to the person, not to a pot, acid or meth-head. The girls early resort to sexual seductiveness and when the therapist does not respond, they soon begin to act very much like the nagging, bitchy and pushy mother they were determined never to emulate. They declare that all men are weak and worthless, and attempt to denigrate the therapist in much the same way they claim mother disposed of father. The boozers will proudly announce they refused a glass of beer after one swallow, and will reach near temper-tantrum level when this one sip results in an exclusion. The fattys beg not to be excluded for failure to lose a mere "few ounces" of the required weekly poundage. If the therapist maintains an unrelenting consistency and firmness without hostility, the patients then accept the rules and settle down into the next phases of the treatment milieu, although sporadic resurgence or rule-testing must be expected at any time.

Once in the group, almost all patients panic. They contact the therapist by telephone and beg or demand that they be taken back into individual sessions instead of group therapy. This is the first time since dropping out that these adolescents have had to relate to their peers without their crutches, and they dramatically demonstrate that even more than the generation gap they claim to have with their parents, the real alienation is from their peers. All had been on the fringes of legitimate school groups, and all had persistently felt on the outside looking in. When they realize the therapist is not going to protect them from their terror of the group situation, they settle down and begin to discuss their alienation. Much talk evolves around the search for a "me spot," the place where "me" can feel at home. None had found it in their respective homes or peer groups, and came to San Francisco because lore had it that there was a "me spot" here. Drugs either enhanced the belief that one was about to find the "me spot," or they deadened the pain of alienation and the despair there is no spot for me.

As therapy progresses, the patients midway begin to identify with the strength of the therapist in caricature. Where once they seemed bound to unrelenting debasement, they now become super-straight. In shedding their "loser suits" (the name they ascribe to the hippy costume), they begin to resemble Youth for Christ. They begin to vote unreasonably harsh rules on themselves, and do not hear the therapist's caution that they are going too far. During this period should one of their number break a major rule, the response is almost sadistically punitive, and exclusion for the remainder of the session becomes a merciful exit from the group's wrath. Soon this behavior collapses of its own weight, and the patients embark on a slow, steady road to becoming reasonable authorities, or what they call "real cool grown-ups." They recognize the difference between healthy adult and the one whose own interrupted rebellion or unresolved authority problems leads him to seductively provide rationalizations and romaticism to the adolescent's destructiveness. They behave as if they have integrated an ability to rebel in a healthy manner, and they engage the therapist in a delightful give-and-take through which they acquire both self-respect and self-differentiation without losing their respect and appreciation of the therapist. They learn you can disagree and formulate your own beliefs and destiny.

There is shock and sadness when, inevitably, a group member reaches the fourth exclusion and is expelled. With our own increased experience, our more recent groups usually have only one or no failures at all, while our earlier mode was three of the ten members comprising each group.

Discussion

There has been no attempt to present a theory of personality, but rather a treatment technique which is a workable alternative to going after the drug cult adolescent, either with punitive authoritarianism or missionary zeal. The ability of exclusion therapy to involve four out of five youths who come to us, and to "graduate" into adulthood seven or eight of ten of those, compares favorably with the results obtained by more traditional therapies, correctional settings or some newer groups whose initial appeal to the adolescent is that the therapy, too, is somewhat on the periphery of society. It is our conviction, after four years of work, that adolescents want their father figures to be strong, understanding, fair and "square."

Exclusion therapy is not effective with the usual, conventional and non-addictive neuroses, and, therefore, does not supplant traditional or other forms of therapy. Rather, it extends our therapeutic armamentarium to a group of persons who have in the past demonstrated resistence to psychotherapy. Recent application of this technique with adults at the Kaiser Health Care Program in San Francisco has demonstrated the effectiveness of exclusion therapy with the older, more entrenched addicts of the four types previously described in our adolescents. These adult groups employ almost identical procedures with almost identical results.

Exclusion therapy differs from Alcoholics Anonymous, Synanon, and other perpetual techniques in that it does not become a way of life. In contrast to the modalities which resemble ongoing subcultures, Exclusion Therapy views treatment as a terminable vehicle by which the patient is catapulted into the real world where he must live without constant recourse to the group. Consequently, where understanding is the goal, gratification within the group is discouraged in favor of each individual finding his satisfaction outside the group. No in-group dating is permitted, no one sees each other except at schedules appointments in the therapist's office, and an attitude of "us and them," or the group versus the world is prevented from taking root. The group does not become a grotesque stage where the members safely practice a kind of pseudo-hostility and pseudo-sexuality on each other while remaining alienated from the outside world. Each "graduate" takes his rightful place in society. He frequently drops a note to his previous therapist somewhat as a son or daughter, who is independent, writes home. This is how we know that our results are enduring.

The greatest problem has been in finding and training therapists. Most professionals are intrigued by exclusion therapy, but are unable or unwilling to genuinely become an exclusion therapist. Many have attempted compromises, with painful results, both to the therapist and the patient, as these are persons whose adult figures have been one gigantic compromise, and the antidote must be unrelenting firmness. We have not succeeded in training one woman therapist to either her or our satisfaction. It may be that father-deficiency can not be ameliorated by a woman, or it may remain for some gifted woman to successfully modify the technique so that it will be applicable. One professional woman, eager to become an exclusion therapist, was instantly cured of her desire when her first patient stood up and just prior to stakling out declares: "Humpf! You remind me of my Jewish mother!"